2019 BENEFITS GUIDE

HUB

ips ADVISORS

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Take Care of Your Tomorrow!

Personal needs greatly influence the choices we make every day. Young or old, single or married, our needs differ. That's why wants to provide you with the freedom to select quality benefit options that work best for you.

It is important that you take an opportunity to review all of your plan options in detail. You will need to carefully consider each benefit option, its cost and value to you and whether it is appropriate for your personal needs. By taking the time to examine all of your options, you will ensure that your benefits meet those needs throughout the plan year.

The City of La Porte values our employees and recognizes the importance of offering benefits that enhance people's lives. With that in mind, we have good news for 2019!

NEW!

Quick Response (QR) CODES!

You will see these weird looking squares within your benefit guide called QR Codes.

Each of these codes store and transmit data, and you can use them by scanning them with your mobile device if you download a QR Reader from your app store such as the Apple App Store or Android Market.

Please Keep This Guide

It is a valuable resource for you throughout the year.

Your City of La Porte HR Team:

Matt Hartleib, HR Manager (281)470-5025
Lindsey Campuzano, Benefits Specialist (281) 470-5026
Angela Flores, Risk & Safety Specialist (281) 470-5027
Sandra Charles, HR Specialist (281) 470-5024

Benefits Resource List

For more information on the wide range of City of La Porte benefits, programs and tools, contact the following resources:

If You Have Questions About	Contact	By Phone	On the Internet
MEDICAL COVERAGE Directories of network providers, claims status or pre-notification	Aetna	800-872-3862	www.aetna.com
DENTAL COVERAGE	Cigna	800-224-6224	www.mycigna.com
VISION COVERAGE	Avesis	855-214-6777	www.avesis.com
LIFE INSURANCE	Lincoln Financial Group	800-487-1485	www.lfg.com
DISABILITY INSURANCE	Lincoln Financial Group	800-487-1485	www.lfg.com
EMPLOYEE ASSISTANCE PROGRAM	UTEAP	800-346-3549 713-500-3327	www.mylifevalues.com www.uteap.org
RETIREMENT	TMRS	512-476-5576	www.tmrs.org

Eligiblity

If you are a full-time employee who regularly works a minimum of 30 hours per week, you are eligible to participate in The Company's benefit plans.

Dependent Eligibility

Who can you cover on your benefit plans?

You may cover your spouse or civil union partner on our medical, dental, vision, and life insurance plans. If your spouse or civil union partner is a benefit eligible employee at the City of La Porte, you may not cover him/her under spouse life insurance. Your domestic partner or partner in common law marriage is eligible for coverage with a signed affidavit. Children's eligibility varies by plan.

Medical Insurance: A child may be covered under our medical plan through the end of the month during which he/she reaches age 26. Student status does not affect eligibility for medical coverage.

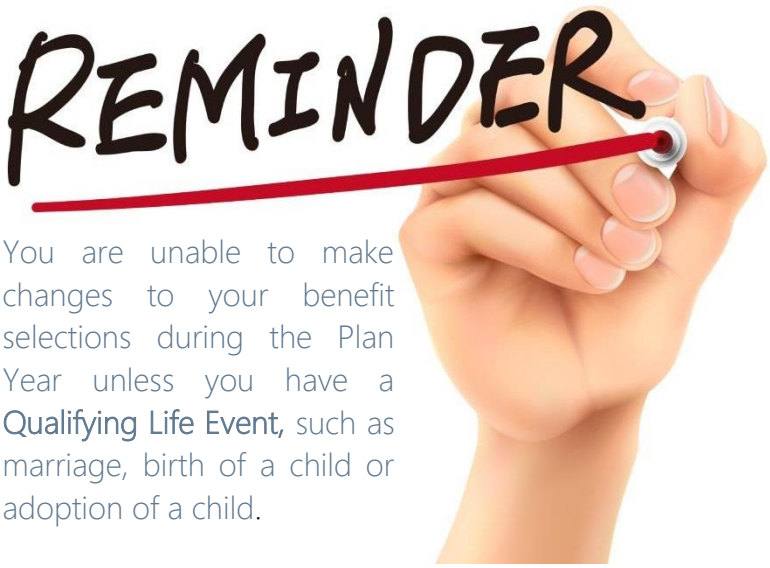
Dental, Vision, and Life Insurance: An unmarried, dependent child may be covered through the end of the month during which he/she reaches age 26.

Flexible Spending Accounts: Claims incurred by you, your spouse, and qualifying child are reimbursable under an FSA. Per federal tax law, claims incurred by an employee's civil union partner or that partner's children are not eligible for reimbursement through the employee's health care or dependent care flexible spending accounts.

You must cover yourself on any plans that you wish to enroll a dependent(s) in. See the Summary Plan Descriptions for more information about dependents and their eligibility.

Dependent Verification Required

Documentation will be required to enroll a dependent in medical, dental or vision coverage. Verification of a dependent can range from a copy of a birth certificate, copy of a marriage license, or a copy of your most recent tax return proving the dependent relationship.



You are unable to make changes to your benefit selections during the Plan Year unless you have a Qualifying Life Event, such as marriage, birth of a child or adoption of a child.

Medical Benefits

Hired Prior to January 1, 2018

Here is a snapshot of the coverage offered through the 2019 medical plans

BENEFITS – Aetna		PPO 500*	HF 1000	HF 1500
Deductible	Network	$500 Individual / $1,500 Family	$1,000 Individual / $3,000 Family	$1,500 Individual / $4,500 Family
	Non-Network	N/A	N/A	N/A
Health Fund Allowance		N/A	$500 Individual/ $1,000 Family	$500 Individual/ $1,000 Family
Out-of-Pocket Maximum		Includes Deductible	Includes Deductible	Includes Deductible
	Network	$3,500 Individual / $10,500 Family	$3,000 Individual / $9,000 Family	$4,200 Individual / $12,600 Family
	Non-Network	N/A	N/A	N/A
Co-insurance	Network	80%	80%	80%
	Non-Network	N/A	N/A	N/A
Lifetime Maximum		Unlimited	Unlimited	Unlimited
		You Pay	You Pay	You Pay
Office Visit	Network	$25 PCP / $40 Spec	Deductible/ 20%	Deductible/ 20%
	Non-Network	N/A	N/A	N/A
Wellness Visit	Network	$0 Copay	$0 Copay	$0 Copay
	Non-Network	N/A	N/A	N/A
In-Patient & Out-Patient Hosp.	Network	Deductible/ 20%	Deductible/ 20%	Deductible/ 20%
	Non-Network	N/A	N/A	N/A
Urgent Care	Network	$40 Copay	Deductible/ 20%	Deductible/ 20%
	Non-Network	N/A	N/A	N/A
Emergency Room	Network	$150 Copay/ Deductible/ 20%	$150 Copay/ Deductible/ 20%	$150 Copay/ Deductible/ 20%
	Non-Network	$150 Copay/ Deductible/ 20%	$150 Copay/ Deductible/ 20%	$150 Copay/ Deductible/ 20%
Prescriptions	Generic/Brand/ Non-Formulary	$10/$30/$60 20% Spec <$100	$10/$30/$60 20% Spec <$100	$10/$30/$60 20% Spec <$100
	Mail Order (90 day) – Mandatory Maintenance	$20/$60/$120	$20/$60/$120	$20/$60/$120
Network Website	www.aetna.com	Select Open Access	Select Open Access	Select Open Access

Medical Costs (Bi-Weekly)	PPO 500		HF 1000		HF1500	
	Non - Tobacco	Tobacco	Non - Tobacco	Tobacco	Non - Tobacco	Tobacco
Employee Only	$23.18	$46.26	$10.48	$33.56	$6.76	$29.84
Employee & Spouse	$127.52	$150.60	$85.00	$108.08	$48.46	$71.54
Employee & Children	$117.74	$140.82	$77.89	$100.97	$43.96	$67.04
Employee & Family	$145.58	$168.66	$102.49	$125.57	$55.70	$78.78

Medical Benefits

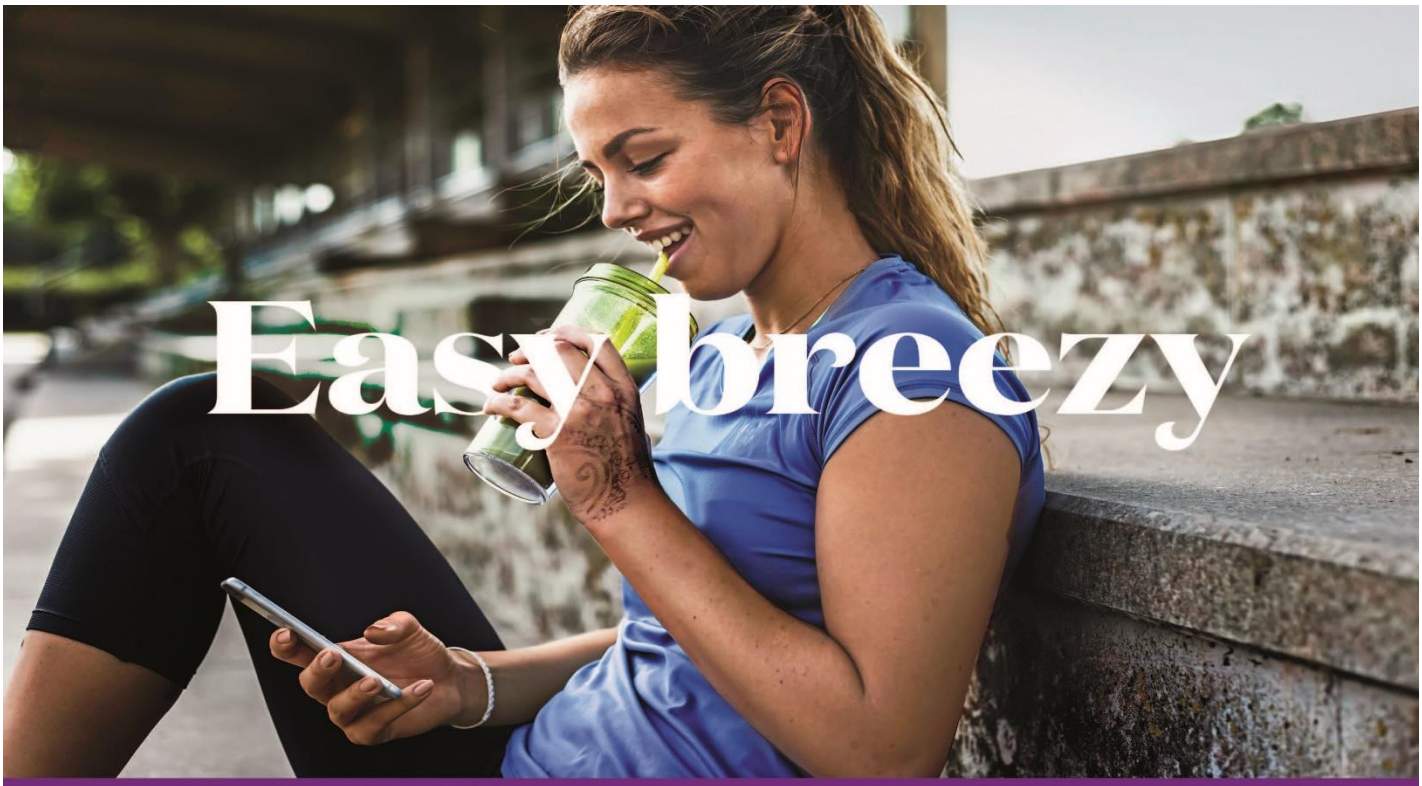
Hired On or After January 1, 2018

Here is a snapshot of the coverage offered through the 2019 medical plans

BENEFITS – Aetna		HF 1500
Deductible	Network	$1,500 Individual / $4,500 Family
	Non-Network	N/A
Health Fund Allowance		$500 Individual/ $1,000 Family
Out-of-Pocket Maximum		Includes Deductible
	Network	$4,200 Individual / $12,600 Family
	Non-Network	N/A
Co-insurance	Network	80%
	Non-Network	N/A
Lifetime Maximum		Unlimited
		You Pay
Office Visit	Network	Deductible/ 20%
	Non-Network	N/A
Wellness Visit	Network	$0 Copay
	Non-Network	N/A
In-Patient & Out-Patient Hosp.	Network	Deductible/ 20%
	Non-Network	N/A
Urgent Care	Network	Deductible/ 20%
	Non-Network	N/A
Emergency Room	Network	$150 Copay/ Deductible/ 20%
	Non-Network	$150 Copay/ Deductible/ 20%
Prescriptions	Generic/Brand/ Non-Formulary	$10/$30/$60 20% Spec <$100
	Mail Order (90 day) – Mandatory Maintenance	$20/$60/$120
Network Website	www.aetna.com	Select Open Access

Medical Costs (Bi-Weekly)	HF1500	
	Non -Tobacco	Tobacco
Employee Only	$6.76	$29.84
Employee & Spouse	$58.30	$81.38
Employee & Children	$48.64	$71.72
Employee & Family	$74.69	$97.77

Aetna – Mobil App



Health management at your fingertips

We know you're busy and that you live life on the go. That's why the Aetna Mobile app makes it easy for you to manage your health wherever, whenever you need to.

aetna®

aetna.com

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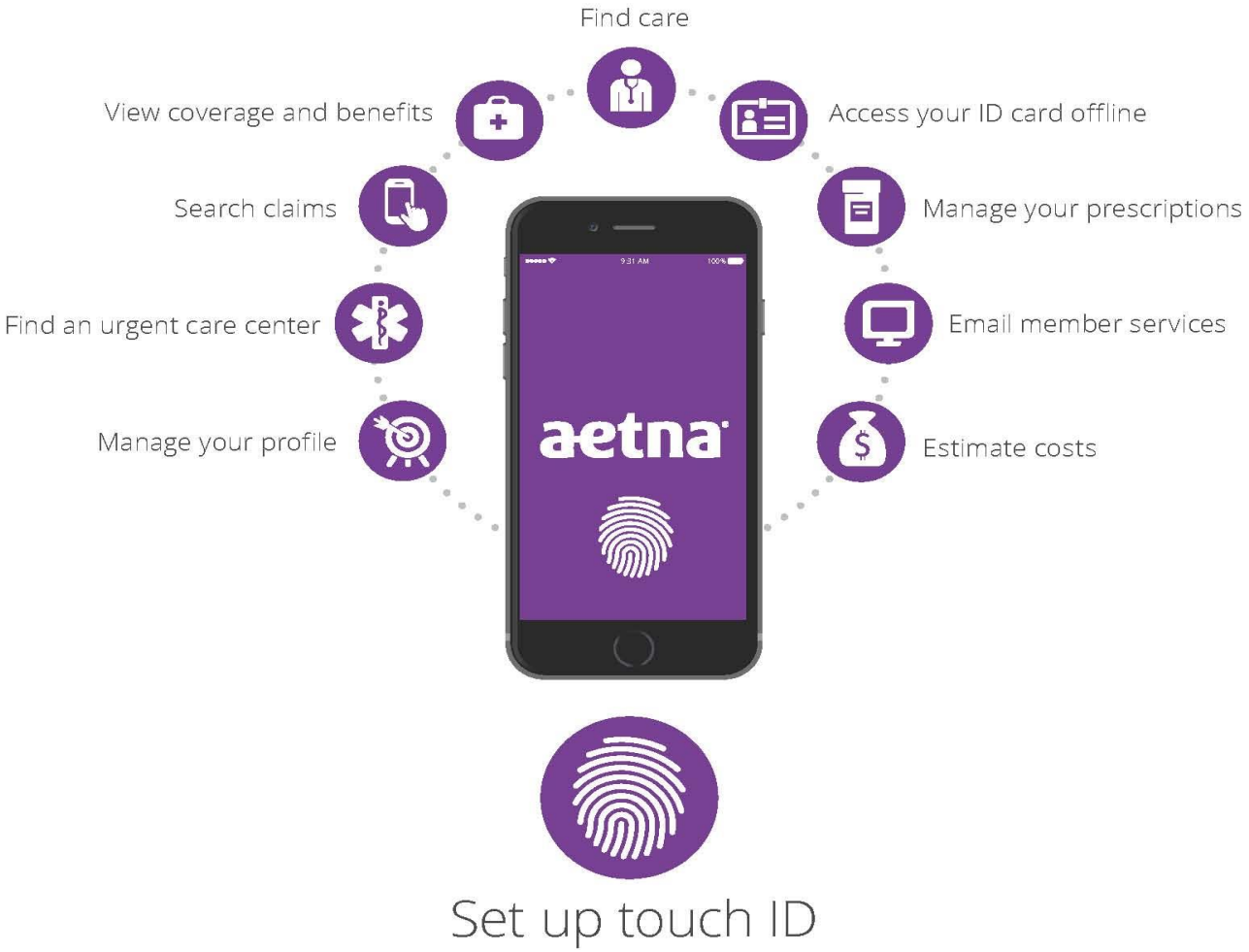
Aetna – Mobil App (Cont.

With the Aetna Mobile app, you can:



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Generic Drugs: Questions and Answers

What are generic drugs?

A generic drug is identical -- or bioequivalent -- to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. Although generic drugs are chemically identical to their branded counterparts, they are typically sold at substantial discounts from the branded price. According to the Congressional Budget Office, generic drugs save consumers an estimated $8 to $10 billion a year at retail pharmacies. Even more billions are saved when hospitals use generics.

Are generic drugs as effective as brand-name drugs?

Yes. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used.

FDA requires generic drugs have the same high quality, strength, purity and stability as brand-name drugs.

For more information about Generic Drugs visit https://www.accessdata.fda.gov/scripts/cder/daf/ or use your QR Scanner.

Not every brand-name drug has a generic drug. When new drugs are first made they have drug patents. Most drug patents are protected for 20 years. The patent, which protects the company that made the drug first, doesn't allow anyone else to make and sell the drug. When the patent expires, other drug companies can start selling a generic version of the drug. But, first, they must test the drug and the FDA must approve it.

Creating a drug costs lots of money. Since generic drug makers do not develop a drug from scratch, the costs to bring the drug to market are less; therefore, generic drugs are usually less expensive than brand-name drugs. But, generic drug makers must show that their product performs in the same way as the brand-name drug.

How are generic drugs approved?

Drug companies must submit an abbreviated new drug application (ANDA) for approval to market a generic product. The Drug Price Competition and Patent Term Restoration Act of 1984, more commonly known as the Hatch-Waxman Act, made ANDAs possible by creating a compromise in the drug industry. Generic drug companies gained greater access to the market for prescription drugs, and innovator companies gained restoration of patent life of their products lost during FDA's approval process.

New drugs, like other new products, are developed under patent protection. The patent protects the investment in the drug's development by giving the company the sole right to sell the drug while the patent is in effect. When patents or other periods of exclusivity expire, manufacturers can apply to the FDA to sell generic versions.

The ANDA process does not require the drug sponsor to repeat costly animal and clinical research on ingredients or dosage forms already approved for safety and effectiveness. This applies to drugs first marketed after 1962.

What standards do generic drugs have to meet?

Health professionals and consumers can be assured that FDA approved generic drugs have met the same rigid standards as the innovator drug. To gain FDA approval, a generic drug must:

- contain the same active ingredients as the innovator drug(inactive ingredients may vary)
- be identical in strength, dosage form, and route of administration
- have the same use indications
- be bioequivalent
- meet the same batch requirements for identity, strength, purity, and quality
- be manufactured under the same strict standards of FDA's good manufacturing practice regulations required for innovator products

OneRx

The OneRx application is a free downloadable app for your smart phone to have instant access to current discounts and coupons for your prescriptions.

Know out-of-pocket costs in real time

- Employees save money by seeing their personalized out-of-pocket for a drug being prescribed at local pharmacies including any special coupons or discounts you can use.

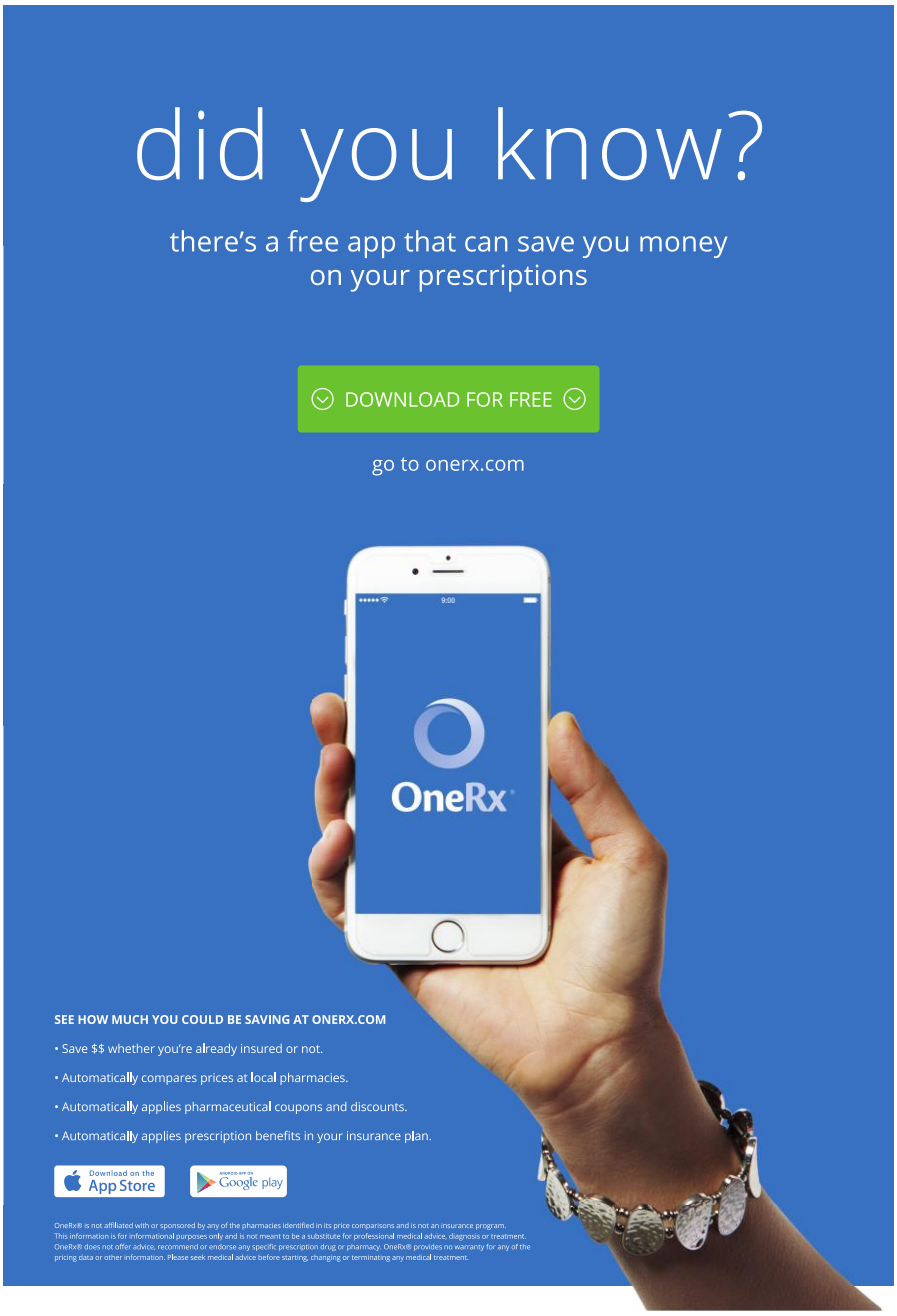
Be alerted to insurance restrictions

- Know if step therapy or a prior authorization is required before you try to fill the prescription.

Stay up to date on coverage and savings

- Track all medications automatically; be kept up to date on the prescription drug list status and all available savings. The average savings for using the OneRx app is $750!

Visit www.onerx.com or scan the QR Code for additional details about OneRx.



Urgent Care vs. Emergency Rooms

Healthcare consumers must educate themselves to recognize the differences between an urgent care facility, emergency rooms and freestanding emergency rooms. Understanding their differences could save you as a consumer thousands of dollars.

Whenever you feel bad or have a child who is under the weather all you want is for yourself or them to feel better. You should take into consideration the severity of the situation, the ER wait time and the hefty bill you will receive. Actually, visiting an urgent care may be a better choice as wait times may be shorter and more affordable.

A majority of Urgent Care Clinics accept insurance and are open all week long, including nights, weekends and holidays. Additionally, instead of having to wait in a waiting room to be seen, some Urgent Care Clinics allow you to call in advance and wait in the comfort of your home until a room becomes available.

Urgent care centers are equipped to handle non-life threatening situations, and many have attending doctors and nurses who have access to x-rays and labs onsite. Most urgent care centers are open late and on weekends and holidays.

Choosing an urgent care center over the ER can save you time and money:

- Average time of an ER visit: 4 hours
- Average cost of an ER visit: $1,757
- Average cost of an urgent care center visit: $162

Visit an urgent care center for these common conditions:

- Flu and cold / High fevers
- Broken bones
- Coughs and sore throat
- Vomiting, diarrhea, stomach pain
- Cuts and severe scrapes
- High fevers

Emergency Rooms

Emergency rooms are meant for true medical emergencies and can handle trauma, x-rays, surgical procedures and other life threatening situations.

Most hospitals have an emergency room that's open 24 hours a day, 7 days a week. If you have a true emergency, go to your nearest emergency room or call 911.

Visit an emergency room if you experience:

- Allergic reactions
- Broken bones
- Chest pain
- Constant vomiting
- Continuous bleeding
- Severe shortness of breath
- Deep wounds
- Weakness or pain in a leg or arm
- Head injuries / Unconsciousness

Surprise Medical Bills

"Surprise medical bill" is a term commonly used to describe charges arising when an insured individual inadvertently receives care from an out-of-network provider. This situation could arise in an emergency when the patient has no ability to select the emergency room, treating physicians, or ambulance providers. Surprise medical bills might also arise when a patient receives planned care from an in-network provider (often, a hospital or ambulatory care facility), but other treating providers brought in to participate in the patient's care are not in the same network. These can include anesthesiologists, radiologists, pathologists, surgical assistants, and others. In some cases, entire departments within an in-network facility may be operated by subcontractors who don't participate in the same network. In these non-emergency situations, too, the in-network provider or facility generally arranges for the other treating providers, not the patient.

I GOT A SURPRISE BILL. WHAT CAN I DO ABOUT IT?

- Call the doctor or provider that sent the bill and discuss your concerns. In most cases, Texas law requires providers to provide an itemized bill on request, so review the charges carefully. Some providers might accept a lower payment.
- For planned procedures, find out in advance whether your providers are contracted with your health plan. This is especially important in the case of facility-based providers, such as radiologists, anesthesiologists, pathologists, and neonatologists. Even if a hospital is in your health plan's network, some doctors who provide services there might not be.
- Call your health plan to make sure the services you will get are covered under your policy. If the services are not covered, you will have to pay the charges.
- Texas law gives patients the right to request estimates of charges. Doctors and other providers and health plans have 10 days to give you the estimates, so you won't be able to get them in cases of emergencies. Some providers and health plans also have cost information on their websites.
- If there aren't any contracted providers available, your health plan might be able to work out a discounted payment. You also might be able to ask your doctor or provider if they'll accept payment options in advance. In some cases, the health plan may be required to make sure you aren't balance billed.

Dental Benefits

Effective January 1, 2019

Here is a snapshot of the coverage offered through the 2019 dental plans.

BENEFITS - Cigna	DHMO*	PPO
Type I – Preventive Services Oral examinations (2 Per Year) X-rays Cleanings (2 Per Year)	$5 Copay See Schedule	No Deductible/ 0%
Type II – Basic Services Fillings Extractions Root Canal	$5 Copay See Schedule	Deductible/ 20%
Type III – Major Services Crowns Removable / fixed bridge-work Partial or complete dentures	$5 Copay See Schedule	Deductible/ 50%
Type IV - Orthodontia Child Only to Age 19	See Schedule	50%
Annual Deductible		
Individual	N/A	$50
Family	N/A	$150
Annual Maximums		
Dental Annual Maximum	N/A	$1,250
Orthodontia Lifetime Maximum	N/A	$1,000
Network Website www.mycigna.com	Cigna DHMO Network	Cigna PPO Network

NOTE: This is a brief summary and not intended to be a contract.

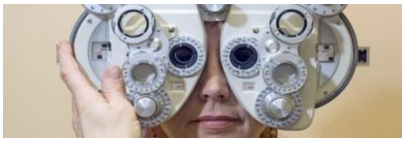
Dental Costs – Semi Monthly	Per Pay Period	Per Pay Period
Employee Only	$5.40	$13.17
Employee + 1	$10.25	$26.24
Employee & Family	$12.61	$48.04

*The DHMO plan requires you to select an in-network primary dentist during enrollment.

For the PPO plan, if you do not enroll when first eligible you will have to be enrolled in the plan for 12 months before Type III and Type IV services will be covered.

Deductions are taken on a pre-paid basis. Ex: deductions during the month of December cover January premium

Vision Benefits



Effective January 1, 2019

This is a snapshot of the coverage offered through the 2019 Vision plans.

BENEFITS		Avesis
Eye Exam	Network Non-Network	$10 Copay Up to $45 Reimbursement
Frames/ Lens		
Single Vision	Network Non-Network	$25 Copay Up to $40 Reimbursement
Bifocal Lenses	Network Non-Network	$25 Copay Up to $60 Reimbursement
Trifocal Lenses	Network Non-Network	$25 Copay Up to $80 Reimbursement
Frames	Network Non-Network	$65 Allowance $65 Reimbursement
Contacts *In Lieu of Glasses		
Network	Medically Necessary Elective	Covered in Full $175 Allowance
Non-Network	Medically Necessary Elective	$250 Allowance $150 Reimbursement
Exam Frequency		12 Months
Lens Frequency		12 Months
Frames Frequency		24 Months
Network Website	www.avesis.com	Avesis Network

NOTE: This is a brief summary and not intended to be a contract.

Vision Costs	Per Pay Period
Employee Only	$3.16
Employee & Spouse	$5.59
Employee & Family	$8.29

Basic Life & AD&D Benefits

Effective January 1, 2019

The City of La Porte provides Basic Life and AD&D (Accidental Death and Dismemberment) insurance for you as a full-time employee at no additional cost. If you would like to purchase additional life insurance for yourself and/or your dependents, please see the Voluntary Life Insurance page for more information.

BENEFICIARY INFORMATION

Remember, it is important to designate beneficiaries for all of your insurance policies that require them. If you don't, laws may cause death benefits to be distributed differently than you had planned resulting in additional taxes and may unnecessarily delay the process of finalizing payment to your loved ones. You should regularly review and, if necessary, update your beneficiary designations. You can update your beneficiary at anytime by *submitting a new beneficiary form to HR*.

BASIC LIFE/AD&D BENEFITS	Lincoln
Class Description	Class 1: Exempt Employees, Fire, EMS, Police; Class 2: Non-Exempt Employees; Class 3: City Managers and Department Directors
Basic Life & AD&D Schedule	Class 1: $20,000 Class 2: $10,000 Class 3: $70,000
Maximum Amount	Class 1: $20,000 Class 2: $10,000 Class 3: $70,000
Employee Age Reduction Schedule	65% @ Age 65 40% @ Age 70, 20% @ Age 75, Terminates at Retirement
Waiver of Premium	Included to age 60
Accelerated Death Benefit	50% of Life Benefit
Conversion	Included
Portability	Not Included

***NOTE:** This is a brief summary and not intended to be a contract.*

How Much Life Insurance Do You Need?

If you're going to achieve all your goals, such as sending your kids to college, retiring in comfort and leaving a legacy, you will need to save and invest throughout your lifetime. But to really complete your financial picture, you'll also need to add one more element: protection. And that means you'll require adequate life insurance for your situation. However, your need for insurance will vary at different times of your life — so you'll want to recognize these changing needs and be prepared to act.

When you're a young adult, and you're single, life insurance will probably not be that big of a priority. And even married couples without children typically have little need for life insurance; if both spouses contribute equally to household finances, and you don't own a home, the death of one spouse will generally not be financially catastrophic for the other.

But once you buy a home, things change. Even if you and your spouse are both working, the financial burden of a mortgage may be too much for the surviving spouse. So, to enable the survivor to continue living in the home, you might consider purchasing enough life insurance to at least cover the mortgage.

When you have children, your life insurance needs will typically increase greatly. In fact, it's a good idea for both parents to carry enough life insurance to pay off a mortgage and raise and educate the children, because the surviving parent's income may be insufficient for these needs. How much insurance do you need? You might hear of a "formula," such as buying an amount equal to seven to ten times your annual income, but this is a rough guideline, at best. You might want to work with a financial professional to weigh various factors – number and ages of children, size of mortgage, current income of you and your spouse, and so on – to determine both the amount of coverage and the type of insurance ("term" or "permanent") appropriate for your situation.

Once you've reached the "empty nest" stage, and your kids are grown and living on their own, you may need to re-evaluate your insurance needs. You might be able to lower your coverage, but if you still have a mortgage, you probably would want to keep enough insurance to pay it off.

After you retire, you may have either paid off your mortgage or moved into a condominium or apartment, so you may require even less life insurance than before. But it's also possible that your need for life insurance will remain strong. For example, the proceeds of a life insurance policy can be used to pay your final expenses or to replace any income lost to your spouse as a result of your death (e.g., from a pension or Social Security.) Life insurance can also be used in your estate plans to help leave the legacy you desire.

As we've seen, insurance can be important at every stage of your life. You'll help yourself – and your loved ones – by getting the coverage you need when you need it.

Voluntary Life & AD&D Benefits

Effective January 1, 2019

VOLUNTARY LIFE BENEFITS	Lincoln	
Employee Life Amount	Increments of $10,000	
Class Description	Class 1: Exempt Employees, Fire, EMS, Police; Class 2: Non-Exempt Employees; Class 3: City Managers and Department Directors	
Employee Guarantee Issue Amount	Initial eligible on or after Jan 1, 2011 to Jan 1, 2015: $80,000; Initial Eligibility after Jan 1, 2015: $150,000	
Employee Maximum Amount	5X Base Annual Salary to $500,000	
Employee Age Reduction Schedule	to 65% at age 65; to 40% at age 70; to 20% at age 75	
Spouse Life Amount	50% of Employee Amount to a maximum of $100,000	
Spouse Guarantee Issue Amount	$40,000	
Spouse Maximum Amount	$100,000	
Child Life Amount	$5,000 or $10,000	
Waiver of Premium	Included to Age 60	
Conversion	Included	
Suicide Clause	24 Months	
AGE RATED PREMIUMS (Rates based on Employee/Spouse)	Employee (Rate Per $1,000)	Spouse (Rate Per $1,000)
AD&D Rate: $.03	Included	Included
Life Rate: Up to 24	$0.10	$0.10
25-29	$0.10	$0.10
30-34	$0.11	$0.11
35-39	$0.13	$0.13
40-44	$0.20	$0.20
45-49	$0.28	$0.28
50-54	$0.45	$0.45
55-59	$0.75	$0.75
60-64	$1.12	$1.12
65-69	$2.12	$2.12
70-74	$3.42	$3.42
75-79	$3.42	$3.42
Child Life Rate (Per $1,000)	$0.20	

NOTE: This is a brief summary and not intended to be a contract.

Guarantee issue Amounts listed are only available to new hires and their spouses. All other eligible employees and spouses will be required to submit Evidence of Insurability for any new coverage amount or increase in coverage amount, except as noted.

Disability Insurance

Effective January 1, 2019

The City of La Porte provides full-time employees with short and long-term disability income benefits. The cost for this coverage is paid in full by your employer. In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income.

SHORT TERM DISABILITY BENEFITS	Lincoln – Option 1
Weekly Percentage	60%
Weekly Maximum	$1,000
Benefit Duration	11 Weeks
Accident Benefit Begin	14th Day
Sickness Benefit Begin	14th Day
Monthly Rate per $10 weekly benefit	$0.35

NOTE: This is a brief summary and not intended to be a contract.

SHORT TERM DISABILITY BENEFITS	Lincoln – Option 2
Weekly Percentage	60%
Weekly Maximum	$1,000
Benefit Duration	9 Weeks
Accident Benefit Begin	30th Day
Sickness Benefit Begin	30th Day
Monthly Rate per $10 weekly benefit	$0.29

LONG TERM DISABILITY BENEFITS	Lincoln
Monthly Percentage	60%
Monthly Maximum	$6,000
Definition of Disability	2 Years Own Occupation
Elimination Period	90 Days
Benefit Duration	Social Security Normal Retirement Age
Definition of Earnings	Base Annual Earnings
Pre-existing Limitation	3 / 12
Mental Nervous Limitations	24 Months per Disability
Drug & Alcohol Limitations	24 Months per Disability
Self Reported Limitations	24 Months

Note: If you are enrolling for Voluntary Disability coverage as a late entrant, you will be required to submit Evidence of Insurability before coverage is approved.

Employee Assistance Program (EAP)

Effective January 1, 2019

The Employee Assistance Program (EAP) can help you resolve problems that affect your personal life or job performance. The Employee Assistance Program (EAP) is offered to all employees and immediate family members through UTEAP. The EAP is paid for by company (or is offered on a voluntary basis). It is a completely confidential counseling program that covers issues such as:

- Legal / Financial
- Depression / Stress
- Drug / Alcohol Abuse
- Emotional Problems
- Financial Pressures
- Grief Issues
- Family / Relationship Problems
- Other Personal Concerns

EAP staff members are available 24 hours a day, 7 days a week, every day of the year by calling 713-500-3327. Staff members are highly trained professionals with experience in family, personal, work related and substance abuse issues.

Flexible Spending Account

Effective January 1, 2019

A Flexible Spending Account, or FSA, lets you set aside pre-tax money from your paychecks to spend on out-of-pocket healthcare expenses (i.e. co-pays, deductibles, over-the-counter items, etc.,). Money that goes into an FSA is pre-tax, so by anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Health Care Reimbursement FSA

This program lets employees pay for certain IRS-approved medical care expenses not covered by their insurance plan with pre-tax dollars. The annual maximum amount you may contribute to the Health Care Reimbursement FSA is $2,700. Some examples include:

- Deductible, Prescriptions & Doctor Visit Co-Payments
- Over-the-Counter Medicines with a Prescription
- Vision services, including Lasik Eye Surgery, Glasses & Contacts
- Hearing services, including hearing aids and batteries
- Orthodontics, Dental deductibles and coinsurance
- Acupuncture

Dependent Care FSA

The Dependent Care FSA allows employees to use pre-tax dollars towards qualified dependent care for children under the of age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 for 2018, (or $2,500 if married and filing separately).

Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

FSA Smart Tips

Cover any significant medical expenses early in the year using your FSA. You'll spend the remainder of the year paying yourself back with the regular payroll deductions.
Save your receipts as proof of purchase in order to be reimbursed for your health care expenses from your FSA. So if you are making purchases that are eligible for reimbursement, you'll want to keep them separate from other items.
Take advantage of the pre-tax savings and use your FSA dollars. Remember, unused money in an FSA at the end of the year is lost.

Medical Eligible Expenses for FSA

Acupuncture	Lifetime Care—Advance Payments
Alcoholism	Lodging - for medical care
Ambulance	Long-Term Care
Artificial Limb	Meals - for medical care
Artificial Teeth	Medical Conferences
Bandages	Medical Information Plan
Breast Reconstruction Surgery	Medical Services
Birth Control Pills	Medicines (excluding over-the-counter without an Rx)
Braille Books and Magazines	Nursing Home
Capital Expenses - ramps, rails, etc.	Nursing Services & Home Care
Car - special design	Operations
Chiropractor	Optometrist
Christian Science Practitioner	Organ Donors
Contact Lenses	Osteopath
Crutches	Oxygen
Dental Treatment (not teeth whitening)	Pregnancy Test kit
Diagnostic Devices	Prosthesis
Disabled Dependent Care Expenses	Psychiatric Care
Drug Addiction - inpatient treatment	Psychoanalysis
Drugs (excluding over-the-counter)	Psychologist
Eyeglasses	Special Education
Eye Surgery	Sterilization
Fertility Enhancement	Stop-Smoking Programs
Founder's Fee - care at retirement home	Surgery
Guide Dog or Other Animal	Telephone for hearing-impaired
Health Institute	Television for hearing impaired
Health Maint. Org. (HMO)	Therapy
Hearing Aids	Transplants
Home Improvements - ramps, lifts, etc.	Transportation - for medical care
Hospital Services	Trips - for medical care
Insurance Premiums - see IRS list	Vasectomy
Laboratory Fees	Vision Correction Surgery
Lead-Based Paint Removal	Weight-Loss Program
Learning Disability	Wheelchair

Using your mobile device scan the QR Code to get more information about HSA and FSA eligible expenses.

What Constitutes a Qualifying Life Event?

	Benefits Allowed to Change									
Qualifying Life Event	Medical	Dental	Vision	Supp. EE Life	Vol. Sp. Life	Vol. Child Life	Dep. Care	Health Care	Beneficiaries	**Documentation**
Change in marital status: · Marriage · Divorce or Annulment · Legal Separation · Domestic Partner Dissolution · Death of Spouse	√	√	√		√		√	√	√	Marriage Certificate Divorce Decree Final Court Document Notarized Statement of Disenrollment Death Certificate
Change in the number of dependents: · Birth · Adoption · Guardianship of a Child · Death of a Dependent	√	√	√			√	√	√	√	Birth Certificate, Hospital Announcement Adoption Agreement Court Decree for Guardianship Death Certificate
Dependent Becomes Eligible	√	√	√	√	√	√	√	√	√	Provide Name, Social Security Number, and Date of Birth for dependents
Dependent Loses Other Coverage	√	√	√				√	√	√	Proof of Loss of Coverage, such as termination letter; Certificate of Creditable Coverage
Dependent Gains Other Coverage	√	√	√				√	√	√	Proof of Coverage with start date of benefits and name(s) of covered dependents
A change in Employee's, spouse's, or dependent's work hours (including a switch between full and part-time status)	√	√	√				√	√	√	Proof of loss of Coverage due to employment status change, such as a Certificate of Creditable Coverage or letter from the company
Change in Dependent Care Costs							√			Letter from your Day Care Provider
Court Ordered Dependent, add or drop from coverage	√	√	√			√	√	√	√	Contact your Benefits Team Directly

For more information on Qualifying Events scan the QR code with your mobile device.

Glossary of Health Coverage & Medical Terms

This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

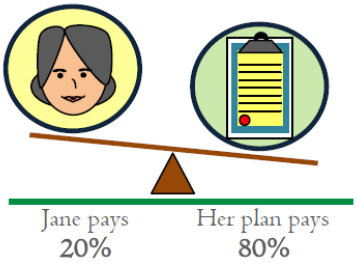
For a digital version of the Glossary of Health Coverage & Medical Terms scan the QR code with your mobile device.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

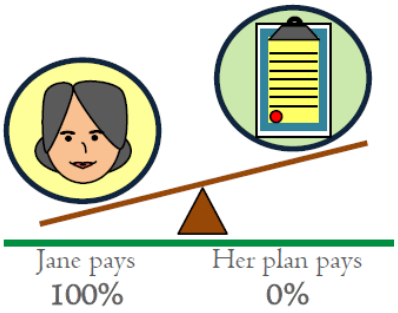
Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance *plus* any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.



Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met
your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Glossary of Health Coverage & Medical Terms (continued)

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

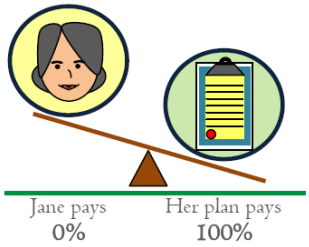
Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Glossary of Health Coverage & Medical Terms (continued)

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.



Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Glossary of Health Coverage & Medical Terms (continued)

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

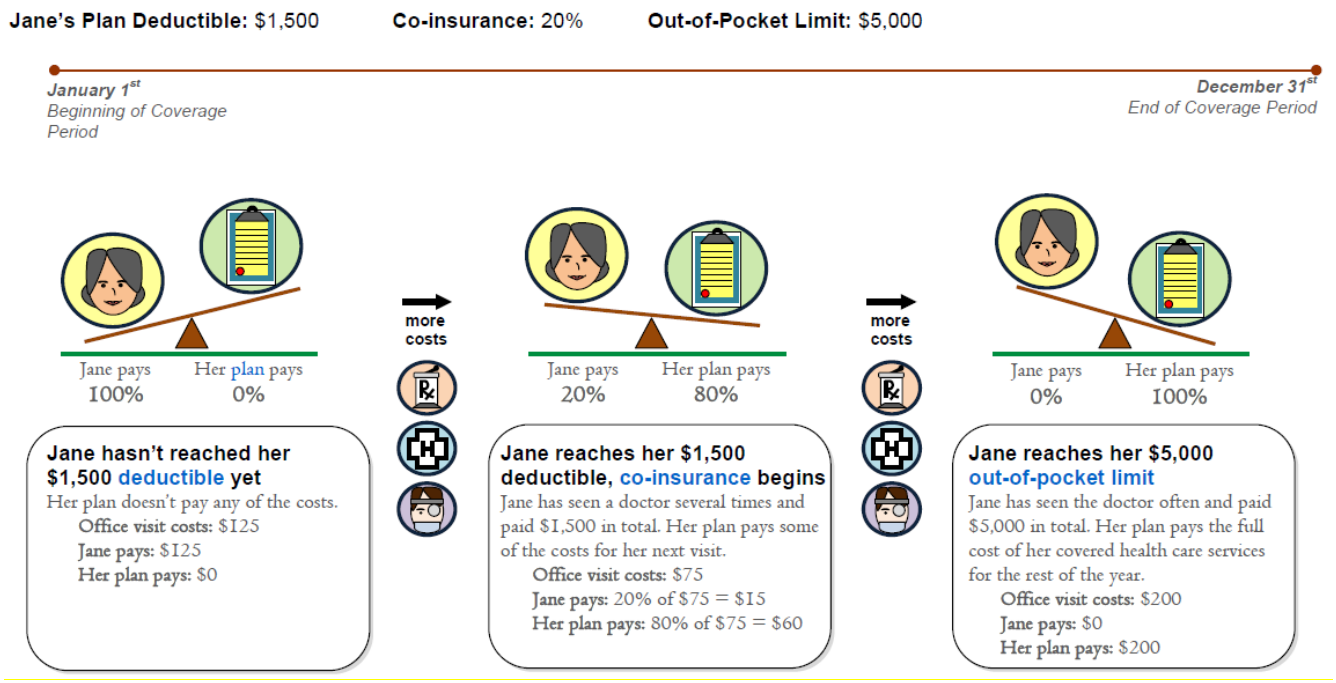
Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example



Annual Notices

Health Insurance Portability and Accountability Act (HIPAA) requires a group health plan to provide a Notice of Special Enrollment Rights annually to all employees who are eligible to participate in the plan.

Notice of Special Enrollment Rights

"Special Enrollment Rights"
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the City of La Porte HR Team.

Women's Health and Cancer Rights

Notice of Rights to Reconstructive Surgery Following Mastectomy
The Women's Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage must be provided in a manner determined in consultation with the attending physician and patient.

This coverage may be subject to co-payments, annual deductibles and co-insurance provisions as is deemed appropriate and as is consistent with the co-payments, annual deductibles and co-insurance for other benefits under the plan or coverage. Federal law requires this coverage. In addition, our Plan will not deny you eligibility or continue eligibility to enroll or renew coverage under the terms of the Plan, solely for the purpose of avoiding this coverage, or to penalize incentives (monetary or otherwise) to an attending provider, to include the provider to provide care to you in a manner inconsistent with the coverage required under the Women's Health and Cancer Rights Act of 1998.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Annual Notices (continued)

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private.

You have the right to inspect and copy protected health information which is maintained by and for the plan for enrollment, payment, claims, and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Benefits Administration.

DISCLAIMER: The HIPAA Privacy Rule is effective beginning April 14, 2003. The Privacy Rule is intended to safeguard protected health information (PHI) created and held by health care providers, health plans, health information clearing houses and their business associates. The provisions of the Privacy Rule have significant impact on those who deal with health information and on all citizens with regard to their personal PHI. Our health insurance broker and all of our contracted plans adhere to the HIPAA Privacy Rule.

This is not a Grandfathered plan.

Important Notice from City of La Porte
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of La Porte and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City of La Porte has determined that the prescription drug coverage offered by Aetna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current City of La Porte coverage will be affected. *See* pages 7-9 of the CMS Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/Creditable_Coverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current City of La Porte coverage, be aware that you and your dependents will be able to get this coverage back.

Annual Notices (continued)

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with City of La Porte and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage….

Contact the Medicare office for further information at 866-746-4234. **NOTE:** You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through City of La Porte changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage….

More detailed information about your Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You Handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

For people with limited income and resources, extra help in paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 1-800-772-1213
(TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2019
Name of Entity/Sender: City of La Porte

Annual Notices (continued)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website:http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Annual Notices (continued)

HEALTH INSURANCE MARKETPLACE
COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Part A

General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace ended January 31, 2018 unless you qualify for a Special Enrollment Period.

Can I Save Money on My Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How much is the tax penalty if I don't have health coverage in 2018?

If you don't have health insurance in 2018, you'll pay the **higher** of these two amounts:

- **2.5% of your yearly household income** (Only the amount of income above the tax filing threshold, about $10,150 for an individual in 2014, is used to calculate the penalty.) The maximum penalty is the national average premium for a Bronze plan.
- **$695 per person ($347.50 per child under 18)** The maximum penalty per family using this method is $2,085.

Annual Notices (continued)

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the City of La Porte HR Team.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Part B

Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer name: City of La Porte
2. Employer Identification Number (EIN): 74-6001552
3. Employer address: 604 W. Fairmont Pkwy.
4. Employer phone number: (281) 471-5020
5. City: La Porte
6. State: TX
7. ZIP code: 77571
8. Who can we contact about employee health coverage at this job? Human Resources
9. Phone number: (if different from above)
10. Email address: HR@laportetx.gov

604 W. Fairmont Pkwy.
La Porte, TX 77571
(281) 470-5028